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	15C0001168	A. BUILDING 00 B. WING	06/30/2011

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ST FRANCIS MOORESVILLE SURGERY CENTER LLC	1215 HADLEY RD STE 100 MOORESVILLE, IN46158

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S0000	This visit was for a State licensure survey. Facility Number: 012149 Survey Date: 6-29/30-11 Surveyors: Jack I. Cohen, MHA Medical Surveyor John Lee, RN Public Health Nurse Surveyor QA: claughlin 07/18/11	S0000		
S0153	410 IAC 15-2.4-1(c) (5) (C) Require that the chief executive officer develop and implement policies and programs for the following: (C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies. Based on document review and interview,	S0153	Correction of Deficiency	08/19/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	the facility failed to follow its policy to provide orientation of all new employees to the facility and to the employee's specific job for 2 of 2 (P#1 and P#2) personnel files reviewed. Findings: 1. Review of facility policy 304, entitled Employee Orientation and Continuing Education, indicated all employees will be required to attend a General Orientation and each individual employee will be required to complete a job specific orientation. It further indicated documentation of orientation will be maintained in employee files. 2. The above-mentioned policy made no distinction between directly-employed and contracted Team Members. 3. On 6-30-11 at 11:30 am, employee #A4 was requested to provide documentation of a General Orientation and a job specific orientation for contracted employees. 4. Review of 2 contracted employee personnel files, P#1 and P#2, both radiological techs, indicated, for both, there was no documentation of General Orientation and a job specific orientation.		Rewrite policy #304 “Employee Orientation & Continuing Education” to include direct employees as well as contracted/agency personnel. Create files for Contracted/Agency personnel to include orientation check sheet Prevention of reoccurrence Staff files are reviewed annually. Contracted/agency files will be included in the review process. Responsibility Office Manager/Administrative Assistant will assist in maintaining contracted/agency files Ultimate responsibility falls on the Director	

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	5. On 6-30-11 at 4:35 pm, employee #A4 was requested to provide the above-mentioned documentation on the above-mentioned employees and none was provided prior to exit.			
S0156	410 IAC 15-2.4-1 (c)(5) (E) Require that the chief executive officer develop and implement policies and programs for the following: (E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process. Based on document review, the facility failed to follow its policy to maintain annual performance evaluations for 2 contracted employees. Findings: 1. Review of facility policy 315, entitled Performance Appraisals, indicated it is the policy of the Center to conduct performance appraisals on all Team Members annually.	S0156	Correction of Deficiency Job descriptions will be obtained from contracted services Annual evaluations are created from job descriptions Annual evaluations are completed and place in the file Prevention of reoccurrence A reminder is posted on the calendar to do evaluations in December &/or January and will reoccur automatically. Responsibility This is the directors responsibility	08/19/2011

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	2. The above-mentioned policy made no distinction between directly-employed and contracted Team Members, nor did it indicate any other facility's personnel evaluation would be acceptable to the Center. 3. On 6-30-11 at 11:30 am, employee #A4 was requested to provide documentation of Center performance appraisal for contracted employees P#1 and P#2. 4. Review of contracted employee personnel files, P#1 and P#2, both radiological techs, indicated, for both, there were no performance evaluations by any authorized Center person. 5. On 6-30-11 at 4:35 pm, employee #A4 was requested to provide documentation a person authorized by the Center had performed a personnel evaluation on the above-mentioned contracted employees and none was provided prior to exit.			

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S0162	410 IAC 15-2.4-1 (c)(5) (G) Require that the chief executive officer develop and implement policies and programs for the following: (G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care. Based on document review and interview, the facility failed to ensure cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice for 1 (MD#7) of 7 physicians. Findings: 1. Review of facility policy H03.00.00 Q0800 entitled Anesthesia: General, Monitored, Regional and Local Infiltration, indicated only practitioners who perform Moderate Sedation and are not anesthesiologists need to have proof of CPR. 2. Review of 7 physician credential files indicated MD#7 had no documentation of current CPR competency, had passed a written test but not passed a skills test to determine that physician's competency to administer CPR.	S0162	Correction of Deficiency Review all Medical Staff files Determine which practitioners have requested moderate sedation privileges Ensure there is a copy of a current CPR card present Prevention of reoccurrence CPR expiration is entered in AdvantX, allowing tracking of credentials about to expire Responsibility This is the directors responsibility	08/19/2011

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	3. On 3-10-10 at 2:30 pm, upon interview, employee #A4 indicated MD#7 did perform moderate sedation and the employee could not provide, prior to exit, any documentation of CPR competency by MD#7			
S0172	410 IAC 15-2.4-1 (c)(5) (L) Require that the chief executive officer develop and implement policies and programs for the following: (L) Maintaining personnel records for each employee of the center which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable. Based on document review and interview, the facility failed to follow its policy to provide documentation of continuing education for 2 of 2 (P#1 and P#2) personnel files reviewed. Findings: 1. Review of facility policy 304, entitled	S0172	Correction of Deficiency Proof of continuing education will be obtained from contracted/agency personnel and is accepted by the Center Prevention of reoccurrence Proof of continuing education will be requested annually at the time of the annual evaluation for the contracted/agency personnel Responsibility	08/19/2011

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	Employee Orientation and Continuing Education, indicated documentation of continuing education will be maintained in employee files. 2. The above-mentioned policy made no distinction between directly-employed and contracted Team Members, nor did it indicate any other facility's continuing education activity would be acceptable to the Center. 3. On 6-30-11 at 11:30 am, employee #A4 was requested to provide documentation of continuing education for contracted employees. 4. Review of 2 contracted employee personnel files, P#1 and P#2, both radiology techs, indicated, for both, there was no documentation of continuing education. 5. On 6-30-11 at 4:35 pm, employee #A4 was requested to provide the above-mentioned documentation for both of the above-mentioned contracted employees and none was provided prior to exit.		Office Manager/Administrative Assistant will assist in maintaining contracted/agency files Ultimate responsibility falls on the Director	

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S0230	410 IAC 15-2.4-1(e)(5) The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following: (5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility.			
	Based on document review and interview, the facility failed to have a properly composed utilization review committee. Findings: 1. Review of Utilization Review committee documents indicated there were only 2 physicians with no financial interest who were members of the Utilization Review committee. 2. On 6-30-11 at 3:15 pm, upon interview, employee #A4 indicated there were only 2 members of the Utilization Review committee.	S0230	Correction of Deficiency Obtain one more member of the Utilization Review committee E-mail sent to a new practitioner enquiring about interest to assist in the utilization review process Prevention of reoccurrence Fill the empty slot. If one decides not to continue, request replacement recommendation. Responsibility This is the directors responsibility	08/19/2011

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S0310	410 IAC 15-2.4-2(a)(1) The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor. Based on document review, the facility failed to include 2 services furnished by a contractor and 1 directly-provided service, in its quality assessment performance improvement (QAPI) program. Findings: 1. Review of the facility's QAPI program indicated it did not include the contracted services of security guards and tissue transplant providers 2. Review of the facility's QAPI program indicated it did not include the directly-provided service of radiology. 3. On 6-30-11 at 1:15 pm, upon interview. employee #A4 was requested to provide documentation of inclusion of the above services and the employee indicated those services were not included in the facility's QAPI program. No documentation was provided prior to exit.	S0310	Correction of Deficiency Add security to external vendor dashboard for QA monitoring Add Tissue Transplant providers (Osprey, Biomed, Wright Medical, Stryker) to external vendor dashboard for QA monitoring Radiology Services were already present on the external vendor dashboard for QA monitoring Prevention of reoccurrence Monitor and update external vendor dashboard quarterly Responsibility This is the directors responsibility	07/21/2011

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S0616	410 IAC 15-2.5-3(c)(3) An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows: (3) The center shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. Each entry must be authenticated in accordance with the center and medical staff policies. Based on document review and interview, the facility failed to ensure that a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries and each entry must be authenticated in accordance with the center and medical staff policies for 1 of 23 medical records (MR) reviewed (Patient #8). Findings include: 1. Review of policy/procedure #HIS1.03, Medical Record Entries and Authentication, indicated the following; "3. All entries must be authenticated by written signature or identifiable initials or computer key signatures." This policy/procedure was last reviewed/revised on 11-16-09.	S0616	Correction of Deficiency The current policy accepts the hospital policy regarding authentication of signatures on medical records. Make this policy the Center's policy to include how electronic signatures will be authenticated and how the integrity and security of the electronic signature will be protected. Obtain statement from each practitioner stating their electronic signature code will not be shared. Prevention of reoccurrence At the time of credentialing the practitioner will include a signed statement to the effect they will not share their electronic signature code with anyone. Responsibility Changing the policy and obtaining signed statements is the responsibility of the Director who will have some assistance in sending and receiving statements from the	08/19/2011

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	The policy/procedure did not address how electronic signatures would be authenticated and how the integrity and security of the electronic signature would be protected. 2. Review of patient #8's MR indicated the Operative Report was signed by MD #3 with an electronic signature. 3. On 06-30-11 at 1500 hours, staff #42 confirmed that MDs #3 had not signed a statement that the electronic signature code was his/her own and would not share the electronic signature code with others.		Office Manager/Administrative Assistant.	
S0622	410 IAC 15-2.5-3(c)(6) An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows: (6) The center shall have a system of coding and indexing medical records which allows for timely retrieval of records by diagnosis and procedure, physician, and condition on discharge, in order to support continuous quality assessment and improvement activities. Based on document review and interview, the facility failed to have documentation of a log or index that included diagnosis. Findings:	S0622	Correction of Deficiency Diagnosis entry now occurs in a system called AdvantX. Retrieval by diagnosis can now happen through this system Prevention of reoccurrence Diagnosis will be entered routinely	06/30/2011

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	1. Review of a facility document used an an indexing system for retrieval, indicated it did not include the patient's diagnosis. 2. On 6-30-11 11:30 am, employee #A4 was requested to provide documentation of a log or index that included diagnosis. 3. Review of a document used an an index for retrieval of patient records indicated the patient's diagnosis was not included. 4. On 6-30-11 at 2:10 pm, upon interview, employee #A4 indicated the index did not include the patient's diagnosis and no other documentation was provided prior to exit.		into AdvantX at the time of scheduling. Responsibility This is the responsibility of the Director, with the assistance of the scheduler.	
S0630	410 IAC 15-2.5-3(d) (d) The medical record must contain sufficient information to: (1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of the patient's stay in the center and the results. Based on document review, the facility failed to ensure that the medical record (MR) contain sufficient information to justify the treatment for 4 of 23 MRs	S0630	Correction of Deficiency Education of staff to write RVVO orders prior to administration of orders. Educate IMPACT Center	08/19/2011

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	reviewed (Patient #2, 7 and 14). Findings include: 1. Review of patient #2's MR indicated the patient was administered an IV of Ringers Lactate 1000 cc to KVO. The patient's MR lacked documentation of a physician's order and signature for an IV of Ringers Lactate 1000 cc to KVO. 2. Review of patient #6's MR indicated that a Physician's IMPACT Center Post-Operative Order was written without a date and time for the following; "Admit patient as inpatient to unit: Orthopedic unit. Review of patient #6's MR indicates that a Physician's Order was written on 02-18-11 at 1313 hours as follows; "Discharge when criteria met." The patient's MR indicated the patient was discharged to home. It could not be determined why there was inpatient admission orders and discharge orders. 3. Review of patient #7's MR indicated the patient was administered Norco 7.5 mg ii PO on 02-24-11 at 1145 hours. Review of patient #7's MR lacked documentation of a physician's order for Norco. 4. Review of patient #14's MR indicated		practitioners not to write Inpatient orders for Outpatients. Prevention of reoccurrence Trend chart audits Monitor charts for Inpatient orders written by IMPACT Center practitioners. Responsibility This is the responsibility of the Director, with the assistance of the clinical staff that will watch for Inpatient orders on the chart and notify the Director when they occur.	

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	the patient was administered Toradol 30 mg IVP on 05-25-11 at 1320 hours. Review of patient #14's MR lacked documentation of a physician's order for Toradol.			
S0772	410 IAC 15-2.5-4(b)(3)(M) These bylaws and rules must be as follows: (3) Include, at a minimum, the following: (M) A requirement that a medical history and physical examination be performed as follows: (i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed. (ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff. (iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy. Based on document review and interview, the facility failed to ensure that each	S0772	Correction of Deficiency Notify Podiatric surgeons H&Ps	08/19/2011

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	patient admitted by a physician who has been granted such privileges by the medical staff or by another member of the medical staff within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report for 3 of 23 medical records (MR) reviewed (Patient #3, 4 and 6). Findings include: 1. Review of patient #3 and 6's MR indicated that MD #1 performed each patient's History and Physical. 2. Review of patient #4's MR indicated that MD #2 performed the patient's History and Physical. 3. On 06-30-11 at 1515 hours, staff #41 confirmed that MD #1 and 2 are not members of the facility's medical staff.		need to be completed by practitioners who are credentialed with the Center Determine which practitioners are writing H&Ps for Podiatric Surgeons who are not credentialed with the Center Send privileging packets to the those practitioners Obtain temporary privileging until permanent privileging can be given. Prevention of reoccurrence Administrative awareness of this requirement Responsibility This is the responsibility of the Director.	

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S0788	410 IAC 15-2.5-4(b)(3)(R) These bylaws and rules must be as follows: (3) Include, at a minimum, the following: (R) A requirement that a physician shall be available to the center during the period any patient is present in the center. Based on interview, the facility failed to have a policy approved by the medical staff requiring physician availability anytime a patient is present in the facility. Findings: 1. On 6-30-11 at 11:30 am, employee #A4 was requested to provide documentation of policy approved by the medical staff requiring physician availability anytime a patient is present in the facility. 2. On 6-30-11 at 4:00 pm, upon interview, employee #A4 indicated there was no policy approved by the medical staff requiring physician availability anytime a patient is present in the facility and no documentation was provided prior to exit.	S0788	Correction of Deficiency Previously existing policy titled "Resolution of Patient Care Issues" has been re-titled to read "Physician Availability" Prevention of reoccurrence Title policies according to applicable standards Responsibility This is the responsibility of the Director	07/25/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001168	A. BUILDING 00 B. WING	06/30/2011

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S1164	410 IAC 15-2.5-7(b)(4)(B)(i) (b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows: (4) The patient care equipment requirements are as follows: (B) All patient care equipment must be in good working order and regularly serviced and maintained as follows: (i) All patient care equipment must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule. Based on document review and interview, the facility failed to test 1 piece of equipment in accordance with acceptable standards of practice or in accordance with the manufacturer's recommended maintenance schedule. Findings: 1. On 6-29-11 at 9:30 am, employee #A1 was requested to provide a facility policy or the manufacturer's recommended maintenance schedule for the emergency call (code) system. 3. On 6-30-11 at 11:35 am, upon	S1164	Correction of Deficiency Contact Rauland for the maintenance and care instructions, which are not included in the manual the Center has. Prevention of reoccurrence When new equipment is received check for the maintenance and care instructions. If they are missing, request the instructions or a letter from the company. Responsibility This is the responsibility of the Director, with the assistance of the Materials Coordinator	08/19/2011

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	interview, employee #A4 indicated there was no policy or manufacturer's recommended maintenance schedule for the emergency call (code) system. No documentation was provided prior to exit.			
S1166	410 IAC 15-2.5-7(b)(4)(B)(ii) (b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows: (4) The patient care equipment requirements are as follows: (B) All patient care equipment must be in good working order and requlary serviced and maintained as follows: (ii) There must be evidence of preventive maintenance on all patient care equipment. Based on document review and interview, the facility failed to provide preventive maintenance (PM) on 1 piece of patient care equipment. Findings: 1. On 6-29-11 at 9:30 am, employee #A1 was requested to provide documentation of PM on the emergency call (code) system.	S1166	Correction of Deficiency Emergency Call system is tested routinely and documentation was provided. Prevention of reoccurrence Better organization of documents Responsibility This is the responsibility of the Director	06/30/2011

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	2. On 6-30-11 at 11:35 am, upon interview, employee #A4 indicated there was no documentation on the emergency call (code) system. No documentation was provided prior to exit.			
S1168	410 IAC 15-2.5-7(b)(4)(B)(iii) (b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well being of patients are assured as follows: (4) The patient care equipment requirements are as follows: (B) All patient care equipment must be in good working order and regularly serviced and maintained as follows: (iii) Appropriate records must be kept pertaining to equipment maintenance, repairs, and electrical current leakage checks and analyzed at least triennially. Based on document review and interview, the facility failed to ensure records of preventive maintenance (PM) for 12 pieces of patient care equipment being analyzed at least triennially to ensure the actual PM matched the manufacturer's recommendation for PM. Findings:	S1168	Correction of Deficiency The Center has a new license. Moving forward the Center will begin a triennial PM on check on equipment to ensure PMs are done in accordance with manufacturer's instructions. Prevention of reoccurrence 1/3 of the PMs will be reviewed annually so that all PMs are rotated through every 3 years.	08/19/2011

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	1. On 6-29-11 at 9:30 am, employee #A1 was requested to provide documentation of triennial analysis of an anesthesia machine, defibrillator, EKG machine, emergency call (code) system, overhead operating room swing light, patient stretcher (bed), radiology equipment, sterilizer, suction machine, surgical table and wheelchair to determine the PM conducted was in accordance with the manufacturer's recommendation or facility policy, as appropriate.. 2. On 6-30-11 at 12:30 pm, upon interview, employee #A4 indicated there was no documentation of triennial analysis of the above equipment and no documentation was provided prior to exit.		Responsibility This is the responsibility of the Director	
S1210	410 IAC 15-2.5-8(c)(1) (c) All centers shall comply with all regulations set forth in this rule and with 410 IAC 5, when radiology services are provided on-site by the center, including, but not limited to the following: (1) Radiology services must be supervised by a radiologist or radiation oncologist.			

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	Based on document review and interview, the facility failed to document radiology services conducted in the facility were supervised by a radiologist or radiation oncologist. Findings: 1. On 6-29-11 at 9:30 am, employee #A1 was requested to provide documentation radiology services conducted in the facility were supervised by a radiologist or radiation oncologist. No documentation was provided prior to exit. 2. On 6-30-11 at 4;15 pm, upon interview, employee #A1 indicated there was no documentation that radiology services conducted in the facility were supervised by a radiologist or radiation oncologist.	S1210	Correction of Deficiency Contact Radiologist to fulfill the supervising radiologists role i. With hospital ii. Or with Cancer Care Establish a contractual agreement Obtain privileging for the Radiologist Prevention of reoccurrence Privileging is renewed bi-annually Responsibility This is the responsibility of the Director	08/19/2011